☐ Scanned

Neuropsychology Consultants

6717 W. Eldorado Parkway, Suite 110
McKinney, TX 75070

214-585-0584 (phone) 214-585-0586 (fax)
www.npconsult.net

Adult Client Information

Date:______________________________

Name:____ Gender:________________

Age:_______ Date of Birth:_________________

Home Address:____

City:________________________________ State:_______ Zip Code:___________

Phone (Preferred):________________ (Secondary):_____________________

Referred by:____

Service Requested:____

Does anyone hold power of attorney for you?____________________________________

Consent for Treatment – Adult

I give my consent to receive psychological and/or neuropsychological services from clinicians of Neuropsychology Consultants.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized or required by law.

I acknowledge that I have had an opportunity to review the HIPAA Privacy Policy Form utilized by Neuropsychology Consultants.

This authorization shall remain in effect for one year from the date of signing or until__________.

____ ___________________________

Signature of Client (or Guardian) Date

Information Regarding Payment for Services

The client's portion of payment for the requested services is due on the date services are rendered. If services are paid for by check and the check is returned as not paid, there is a $35 returned check fee. If we are in-network with your insurance company, we will check your benefits and relay to you the information they provide regarding co-pays, co-insurance, and deductibles. You may want to verify this information for yourself, as insurance companies sometimes handle claims differently than what they quoted initially. We will file your claim according to their requirements.

Please be aware that insurance companies will only cover medically necessary services; they do not consider academic testing medically necessary and will not pay for this type of testing. This includes testing for learning disabilities, including dyslexia or reading learning disability, dyscalculia or math learning disability, dysgraphia or written language/handwriting disability. We are happy to provide this service for you; however, there is a fee for this in addition to your insurance company's co-pay and/or co-insurance; this fee will be discussed with you in advance.

If we are out-of-network for your insurance company, we will let you know the fee for the requested service, which is due at the time of service. We will file your claim if you request that we do so, requesting that any payment go directly to you. It will be up to you to provide any documentation your insurance company may request to consider payment of the claim.

Whether the services we provide are covered by your insurance company depends on the provisions of your plan. Please be aware that there is no guarantee that your insurance company will cover the service(s), even if they initially say they will do so. It has been our experience that insurance companies sometimes deny or reduce coverage based on the terms of your particular plan, the diagnosis, and/or their beliefs about whether the service is medically necessary. Their beliefs may differ from your beliefs, ours, and/or those of the referring physician.

Primary Insurance Company: ____

Secondary Insurance Company: ____

For clients with Medicare, is *the policy holder currently employed?* ____________________

I have read the above information and agree to proceed with the requested services. I also understand that if I do not arrive for a scheduled appointment, there will be a $35 no show/late cancellation fee, as this time has been reserved specifically for me. I understand that this fee will not be covered by my insurance company.

____ ____________________________

Signature of Client (or Guardian) Date

☐ Scanned

This form, when completed and signed by you, authorizes Neuropsychology Consultants to release protected information from your clinical record to the person(s) or entity(s) you designate and to obtain protected information from the person(s) or entity(s) you designate.

Client's Name:____

Date of Birth:______________________________

I authorize the staff of Neuropsychology Consultants to release records or information, OR to obtain records or information regarding the above named person. These records may include any medical records, academic records, psychological or neuropsychological evaluations, treatment notes, diagnosis, recommendations, or any other information that is related to my care.

I authorize my records and information to be released to or obtained from the following individuals or entities:

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

Name:____ Phone:____________________
Address:______________________________________ Fax:______________________

This authorization shall remain in effect for one year from the date of signing or until __________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____ _______________________
Signature of Client (or Guardian) Date